

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN2802	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 11/03/2010
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - MOUNTAIN VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 1360 BYPASS ROAD WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments  Investigation of C/O #26358, #26462, #26399 and #26709 was conducted September 27, 2010-November 3, 2010, at Golden Livingcenter-Mountain View. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Executive Director

(X6) DATE

11-30-10

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V25G11

DEC 02 2010

If continuation sheet 1 of 1